PROMETRIC

Michigan Certified Nursing Assistant Application

Instructions

- Please go to **www.prometric.com/NurseAide/MI** to print the current version of this application and all other forms. **DO NOT submit photocopies** as this may impact the ability to process the application.
- Incomplete, blurred or illegible forms **will not** be processed.
- **To apply online please go to: www.prometric.com/NurseAide/MI.**
- All submitted applications must include the **Payment Form** at the end of the application.
- Please mail completed original forms to **Prometric, ATTN: MI Nurse Aide Program, 7941 Corporate Drive, Nottingham, MD 21236.**

The name you provide on this application **must** match **EXACTLY** the name on your government-issued identification you will provide on the day of testing. If the name does not match **EXACTLY**, you **will not** be permitted to take your exam and **will forfeit** any test fees.

If you have previously taken a nurse aide exam with Prometric and your legal name has changed since then, you **must** provide a **copy** of acceptable legal documentation along with this application. Acceptable documents include marriage certificate; divorce decree; birth certificate; and legal name change court documents. Prometric will be unable to process your application until the legal acceptable documents are received.

- **If applying for Testing Accommodations under the Americans with Disabilities Act (ADA):**
  - Please go to to **www.prometric.com/nurseaide** to print the required ADA Accommodations Request Packet. This packet **MUST** be completed and submitted with this application.
  - Fill out the box below.

I am applying for **Americans with Disabilities Act (ADA) accommodations.** I am requesting testing accommodations and have included the **required ADA Accommodations Request Packet** along with this application. I understand I must request accommodations **30 days in advance of the test date** and not **all** accommodations can be approved.

☐ **Yes** ☐ **No**

Candidate Information

All fields marked with * are required. Print one number/letter in each box where required.

*Have you ever taken a Certified Nurse Aide exam with Prometric? ☐ Yes ☐ No

*Have you ever been a Certified Nurse Aide in the state of Michigan? ☐ Yes ☐ No

If yes, please provide your certification number: _____

*Social Security Number

☐☐☐-☐☐-☐☐☐☐

*First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐

*Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

*Date of Birth (Month/Day/Year) ☐☐/☐☐/☐☐☐☐	Previous name (if applicable):
*Street Address (including Apt. number or P.O. Box, if applicable)	
*City	*State ☐☐ *ZIP Code ☐☐☐☐☐
* Phone Number (including area code) ☐☐☐-☐☐☐-☐☐☐☐	
*Email Address (application will not be processed without an email address)	
Ethnic Group (optional)(check one box) ☐ American Indian or Alaskan Native ☐ Asian American/Pacific Islander ☐ Black/African American ☐ Mexican American ☐ Other Hispanic or Latin American ☐ White ☐ Other	
Gender (check one) ☐ Female ☐ Male	

Certification Option/Eligibility

Please check a certification route.

✓	Certification Route
	Newly Trained Tester. Candidate has completed training from an approved training program within the last 24 months in the state of Michigan. This is for a candidate who has NOT been previously certified in the state of Michigan.
	Lapsed Candidate is lapsed on the Michigan Registry for more than 24 months. Please enter your certification number here:_____
	Reciprocity Candidate trained and tested in one of the Michigan approved states found in the Candidate Information Bulletin at www.prometric.com/nurseaide/mi AND is currently active and in good standing on any state's CNA registry. Active and in good standing is defined as follows: a certified nurse aide who is currently an active CNA and has not been removed from any state Registry for abuse, neglect or misappropriation of resident property. Please list the state that you originally trained and tested in and your certificate number: State 1: ☐☐ Cert No: _____ Please list any other states that you are certified in: State 2: ☐☐ Cert No: _____ State 3: ☐☐ Cert No: _____ State 4: ☐☐ Cert No: _____ State 5: ☐☐ Cert No: _____
	Trained Out-of-State Tester Candidate has completed training from an approved training program in the last 24 months in one of the Michigan-approved states found in the Candidate Information Bulletin at www.prometric.com/nurseaide/mi.

Training Information

This section must be completed for applicants who are applying as a **Newly Trained Tester** or a **Trained Out-of-State Tester.**

***Training Completion Date:** ☐☐/☐☐/☐☐☐☐	*Training Program Code (if available – see completion certificate).
*Name of Training Program	
*Training Program Mailing Address (Street Address or P.O. Box)	Training Program Phone Number:
City State ☐☐ ZIP Code ☐☐☐☐☐	
*Training Instructors Name:	

Test Site Information

Please check one of the following options.

✓	Test Site	
	Testing at your Facility: My training program or employer is scheduling my exam and I will take the exam at their facility. I will give this application form to the facility coordinator. **Do not send to Prometric.**	
	Regional Test Site: I am applying to test at a Regional Test Site. My preferred test site code is listed. *A current list of Test Sites with codes can be found online at www.prometric.com/NurseAideIII*	*Test site code:

Exam Selection and Processing/Exam Fees

- **Acceptable Forms of Fee(s) Payment:** certified check, money order, MasterCard, Visa or American Express. Make certified checks payable to Prometric. **Personal checks** and **cash** are **not** accepted. Fees are **non-refundable and non-transferrable.**
- The **Payment Form** (last page) **must** be submitted with this application **regardless of payment type.**

✓	**Newly Trained Tester**	**Fee**	**Total**
	Written and Clinical Skills	$115	$
	Oral and Clinical Skills (ADA packet required)	$115	$
	One-time Registration Fee (Required each 24-month eligibility period)	$10	$
✓	**Lapsed Candidate**	**Fee**	
	Written and Clinical Skills	$115	$
	Oral and Clinical Skills (ADA packet required)	$115	$
	Registration Fee (onetime fee per eligibility period)	$10	$
✓	**Re-tester**	**Fee**	
	Written or Oral Test ONLY (Oral requires ADA packet)	$30	$
	Clinical Skills Test ONLY	$85	$
✓	**Reciprocity**	**Fee**	
	Reciprocity Application Processing Fee	$20	$
		Total Fee	

An additional rescheduling/no show fee of $25 is required to reschedule an exam appointment with less than six business days notice, no-shows, late arrivals, or not allowed to test. Reschedule fees may apply to roster changes made by IFT testing locations.

Applicant's Affidavit and Candidate Release Statement

- I understand I am responsible for making sure all information provided in this application is completely true and correct.
- I understand that if I have given false information in this application, my nurse aide certification may be invalidated and I could be prosecuted by the state of Michigan.
- I understand if I pass both parts of the Nursing Assistant Competency Exam **OR** if my application for Reciprocity is accepted, I will be placed on the Michigan Nurse Aide Registry.
- I understand I may be asked to play the part of the resident for another candidate on exam day. I do not have any physical, medical or other condition that would be affected in any way by my participation in the exam. I agree I am responsible for my own personal safety both while taking the exam and acting as a resident. I hereby release Prometric, LARA, and their agents and assigns from any responsibility or liability for any claim or damage that may result from my participation in the examination.
- I understand all information required on the registration application may be made available for public disclosure (except for the Social Security Number).

***Candidate Signature (in box below)**

Questions: For additional information, please visit our website at **www.prometric.com/nurseaide.**

Please make a copy of all completed forms for your personal records.

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Payment Form

*Candidate Name: _____

*Date of Birth: _____

Note: You have the option of submitting your application and payment online using your credit card at **www.prometric.com/en-us/clients/nurseaide.**

Credit Card Type (Check One)

☐ MasterCard ☐ Visa ☐ American Express

Card Number	Expiration Date ☐☐/☐☐
Amount $ ___ ___ ___ . ___ ___	C/C Security Code ☐☐☐☐
Name of Cardholder (Print)	
Signature of Cardholder	

Certified Check or Money Order Payments

☐ Certified Check ☐ 3rd Party/Facility Check ☐ Money Order

Certified Check/Money Order/3rd Party/Facility Check Number (one number or letter in each box):
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please mail completed forms, all supporting documentation and fees to:

Prometric
ATTN: MI Nurse Aide Program
7941 Corporate Drive
Nottingham, MD 21236